Workplace Wellbeing in Practice

THE TALKING THERAPIES UK PRACTITIONER SERIES



Workplace Wellbeing in Practice

Delivering manager-conversation and early-identification training

Practitioner level · 9 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the Workplace Wellbeing in Practice course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 2. This printing was set on 21 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

Contents

How to use this manual 1

Part 1 The manager-conversation model 2

1. Training managers in supportive conversations 2
2. Early identification of signs that someone may be struggling 4

Part 2 Organisational-level content and consultancy delivery . . . 5

3. Organisational assessment and action per NG212 5
4. Delivering as a consultancy engagement 11

How to use this manual

This practitioner course teaches the practical delivery of NICE NG212-grounded workplace training. You will study the manager-conversation model in depth, including how to have a supportive, non-judgemental conversation with a team member who seems to be struggling, how to explore without diagnosing, and how to signpost appropriately into occupational health, an employee assistance programme, a GP or internal HR routes, together with proportionate follow-up and record-keeping. The course then teaches early identification of observable workplace indicators, changes in attendance, performance, engagement or presentation, without reducing this to a checklist that encourages labelling colleagues, before turning to the organisational-level content NG212 also requires: assessing workplace risk factors such as job design, workload and change management, and structuring the whole offer as a bespoke consultancy engagement rather than a generic off-the-shelf course. It is intended for practitioners who have completed workplace wellbeing foundations or hold equivalent working knowledge.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at practitioner level and carries 9 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

PART 1

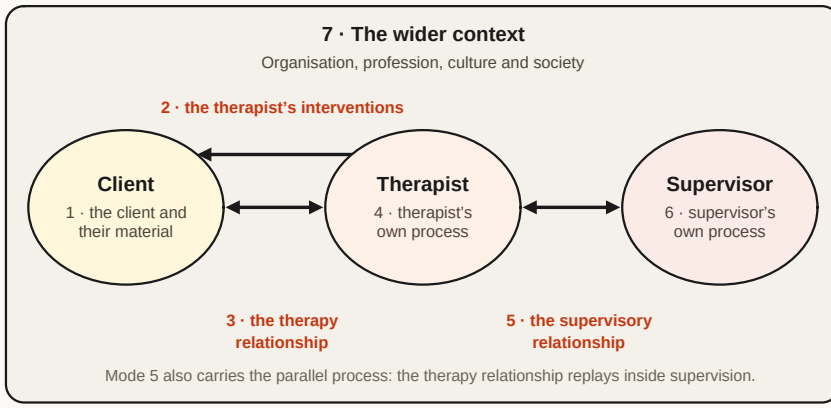
The manager-conversation model

Training managers in supportive conversations, and early identification without informal diagnosis.

CHAPTER 1

Training managers in supportive conversations

This lesson teaches the core skills NICE NG212 highlights for managers: opening a supportive, non-judgemental conversation when a team member seems to be struggling, exploring the person's own account without attempting to diagnose or label what is happening, signposting clearly to appropriate support such as occupational health, an employee assistance programme, a GP or internal HR routes, and following up afterwards in a way that is proportionate rather than either neglectful or intrusive, with a reasonable, appropriately brief record kept of what was discussed and agreed.



After Hawkins and Shohet.

FIGURE 1.1 The seven-eyed model of supervision

Hawkins and Shohet's seven modes give supervision its lenses: the client and their material, the therapist's interventions, the therapy relationship, the therapist's own process, the supervisory relationship itself (including parallel process), the supervisor's process, and the wider organisational and social context around all of it.

Points worth keeping

- Opening a supportive, non-judgemental conversation
- Exploring without diagnosing or labelling
- Signposting clearly to appropriate support routes
- Proportionate follow-up and reasonable record-keeping

PRACTICE TASK

Write the opening two or three sentences a manager could use to start a supportive conversation with a team member who has seemed withdrawn recently.

CHAPTER 2

Early identification of signs that someone may be struggling

This lesson teaches early identification of observable workplace indicators that might suggest someone is struggling: changes in attendance, changes in the standard or pattern of their work, reduced engagement, or a change in presentation or demeanour. The lesson teaches holding these as prompts for curiosity and a supportive opening conversation, never as a checklist used to informally diagnose or label a colleague, and teaches the real risk of over-reading ordinary variation in mood or performance as a sign of a mental health difficulty that may not be present at all.

Points worth keeping

- Observable indicators: attendance, work pattern, engagement, presentation
- Indicators as prompts for curiosity, never for informal diagnosis
- The risk of over-reading ordinary variation in mood or performance
- A supportive opening conversation as the appropriate response to a concern

PRACTICE TASK

List three observable indicators you might notice in a colleague, and write the curious, non-diagnostic question each would prompt you to ask.

PART 2

Organisational-level content and consultancy delivery

Organisational assessment under NG212, and structuring the offer as a bespoke consultancy engagement.

CHAPTER 3

Organisational assessment and action per NG212

The implementation of NICE guideline NG212, which addresses the prevention of mental ill health in the workplace, represents a paradigm shift in how occupational health and organisational psychology are practised in the United Kingdom. For the professional practitioner, this guideline mandates a move away from a purely remedial, individual-focused model of care towards a proactive, systemic approach that addresses the root causes of poor mental wellbeing within the organisational structure. The core premise of this lesson is that workplace mental health is not merely a collection of individual psychological states but is fundamentally shaped by the working environment, the nature of the tasks, and the quality of interpersonal dynamics. Consequently, any effective intervention must begin with a rigorous organisational assessment that identifies these structural and cultural risk factors before any individual-level support is considered. The practitioner must understand that while individual training and support are valuable components of a comprehensive strategy, they are insufficient in isolation if the underlying organisational drivers of distress remain unaddressed. This lesson explores the methodology for conducting a

structured needs assessment, the specific risk factors identified in the evidence base, and the development of a policy-level action plan that aligns with the recommendations of NG212.

The first critical step in this process is the gathering of an organisational picture through a structured needs assessment. This is not a casual inquiry but a systematic, multi-methodological approach to understanding the current state of mental wellbeing within the organisation. The assessment must be designed to capture both quantitative and qualitative data, ensuring that the perspective of employees, managers, and leadership is represented. A robust assessment typically begins with a review of existing organisational data, such as sickness absence rates, employee turnover, grievance procedures, and exit interview data. However, these metrics are often lagging indicators, reflecting problems that have already manifested. Therefore, the assessment must also include prospective measures, such as anonymous employee surveys that specifically probe into the psychological safety of the workplace, the perceived fairness of workload distribution, and the quality of communication channels. The use of validated psychometric tools can provide a baseline against which future progress can be measured, although it is crucial to interpret these scores in the context of the specific organisational culture. The practitioner must be skilled in designing these instruments to avoid leading questions and to ensure that the data collected is actionable rather than merely descriptive. Furthermore, the assessment should include focus groups or individual interviews with a stratified sample of employees to gain deeper insight into the lived experience of the work environment. These qualitative insights often reveal nuances that survey data cannot capture, such as the specific dynamics of a toxic team or the impact of a recent restructure on job security. The ethical considerations of this phase are paramount; practitioners must ensure confidentiality, informed consent, and clear communication about how the data will be used, to build trust and encourage honest participation.

Once the data is collected, the practitioner must analyse it to identify the key workplace risk factors. The evidence base, as synthesised in NG212, highlights several critical areas of risk, primarily job design, workload, working relationships, and change management. Job design refers to the way work is organised, including the degree of autonomy, the clarity of roles, and the balance between demands and resources. Poor job design, characterised by high demands with low control, is a well-established

predictor of stress and burnout. The practitioner must assess whether employees have the necessary resources, such as time, tools, and support, to meet the demands placed upon them. Workload is another central risk factor, but it is not simply a matter of the volume of work. It is the perceived manageability of that workload that determines its impact on mental health. The assessment must distinguish between temporary peaks in workload and chronic, unsustainable demands. The practitioner should look for signs of role ambiguity or role conflict, where employees are unclear about their responsibilities or face contradictory demands from different stakeholders. These factors create cognitive load and emotional strain, contributing to the development of anxiety and depressive symptoms. The analysis of workload should also consider the impact of working patterns, such as shift work, long hours, or the expectation of being available outside of contracted hours, which can erode the boundary between work and personal life, a phenomenon often referred to as the blurring of boundaries.

Working relationships constitute a third major risk factor, encompassing both the quality of interactions with colleagues and the relationship with line managers. The evidence is clear that supportive, respectful, and fair relationships are protective factors for mental health, while conflict, bullying, harassment, and poor management are significant risk factors. The assessment must therefore evaluate the climate of the workplace, looking for indicators of psychological safety, where employees feel able to speak up, make mistakes, and challenge ideas without fear of retribution. The role of the line manager is particularly critical, as they are the primary interface between the organisation and the employee. The assessment should evaluate the training and support provided to managers, their ability to recognise signs of distress, and their capacity to have difficult conversations about performance and wellbeing. Poor management practices, such as lack of feedback, unfair treatment, or failure to address conflicts, can create a toxic environment that undermines the mental health of the entire team. The practitioner must be skilled in identifying these relational dynamics, which may be subtle and embedded in the culture of the organisation. This requires a sophisticated understanding of group dynamics and organisational behaviour, going beyond the individual to examine the systems that facilitate or hinder healthy interactions.

The fourth key risk factor is the way organisational change is managed. Change is an inevitable part of modern organis life, but the process of

change, rather than the change itself, is often the source of stress and distress. Poorly managed change, characterised by a lack of communication, employee involvement, or support, can lead to feelings of uncertainty, loss of control, and resistance. The assessment must evaluate the organisation's change management processes, looking at how decisions are made, how information is disseminated, and how employees are supported through transitions. The practitioner should assess whether the organisation has a clear strategy for managing change, including the provision of training, counselling, and other support services. The impact of change on job security, role clarity, and working relationships must also be considered. For example, a restructure may lead to role ambiguity, increased workload, or conflict between teams, all of which are risk factors for poor mental wellbeing. The assessment should therefore look at the specific changes that have occurred or are planned, and evaluate the organisation's capacity to manage them effectively. This requires a forward-looking perspective, anticipating the potential impacts of future changes and identifying the support needed to mitigate them.

Having identified the risk factors, the practitioner must develop an organisational action plan at the policy level. This is a crucial distinction from individual-level interventions. While individual training, such as resilience workshops or stress management courses, can be beneficial, they are not a substitute for addressing the systemic causes of distress. NG212 explicitly states that individual training should be one part of a larger response, not the whole of it. The action plan must therefore focus on changes to the organisational structure, processes, and culture that will reduce the risk factors identified in the assessment. This may involve changes to job design, such as increasing autonomy, clarifying roles, or redistributing workload. It may involve changes to management practices, such as providing training for managers in supportive leadership, conflict resolution, and mental health awareness. It may involve changes to the way change is managed, such as involving employees in the decision-making process, providing clear communication, and offering support during transitions. The action plan must be specific, measurable, achievable, relevant, and time-bound, with clear responsibilities and timelines for implementation. It must also include a monitoring and evaluation framework to track progress and make adjustments as needed. The practitioner must work with senior leadership to ensure that the action plan is aligned with the

organisation's strategic objectives and has the necessary resources and commitment to be successful.

The development of this policy-level action plan requires a collaborative approach, involving stakeholders from across the organisation. The practitioner must facilitate a process of co-design, where employees, managers, and leaders work together to identify the most effective interventions. This collaborative approach not only ensures that the interventions are relevant and feasible but also builds ownership and commitment to the changes. The practitioner must be skilled in facilitating these discussions, managing conflicts, and ensuring that the voices of all stakeholders are heard. The action plan should be communicated clearly to the entire organisation, with transparency about the reasons for the changes, the expected outcomes, and the support available. This communication is essential for building trust and reducing uncertainty, which are key factors in the successful implementation of organisational change. The practitioner must also be prepared to manage resistance to change, which is a natural part of the process. This may involve addressing concerns, providing additional information, or adjusting the plan to reflect the feedback received.

In conclusion, the organisational assessment and action planning process described in this lesson is a complex, multi-stage endeavour that requires a deep understanding of organisational psychology, the evidence base for workplace mental health, and the specific context of the organisation. The practitioner must be able to gather and analyse data effectively, identify the key risk factors, and develop a policy-level action plan that addresses these factors in a sustainable and effective way. This approach, as mandated by NICE NG212, represents a best practice in occupational health and organisational psychology, and is essential for creating a workplace that supports the mental wellbeing of its employees. The practitioner must remember that individual training is only one part of the solution, and that the real change must happen at the organisational level, through changes to the systems, structures, and cultures that shape the working environment. By following this process, the practitioner can help organisations to create a healthier, more productive, and more resilient workplace, where employees are supported to thrive rather than merely survive.

Points worth keeping

- Workplace risk factors: job design, workload, relationships, change management
- Organisational action planning at policy level
- Individual training as one part of a larger response, not the whole of it
- Gathering an organisational picture through structured needs assessment

PRACTICE TASK

Draft five needs-assessment questions you would ask an organisational client before designing their training.

CHAPTER 4

Delivering as a consultancy engagement

The transition from delivering stand-alone workplace wellbeing half-days to structuring engagements as bespoke organisational consultancy represents a fundamental reorientation of both service model and clinical intent. In the contemporary UK psychological services landscape, practitioners and organisations alike are moving away from the assumption that a single facilitator-led session, however skilfully presented, can generate sustained wellbeing outcomes. Instead, the consultancy engagement is understood as a staged, evidence-informed process that begins long before any content is drafted and extends well beyond the point of delivery. This lesson outlines how a formal needs-assessment phase, the tailoring of intervention content to organisational specificity, and the embedded construction of before-and-after evaluation together constitute the architecture of a credible consultancy offer, and how this architecture aligns with the wider strategic direction of a practice committed to depth, rigour, and measurable impact.

A needs-assessment stage sits at the very threshold of any consultancy engagement, serving not merely as a procedural formality but as the epistemological foundation upon which the entire intervention is built. Without a systematic and rigorous appraisal of the organisational context, any subsequent training or therapeutic input risks being predicated on assumptions that may be empirically unfounded or culturally misaligned. In practice, the needs-assessment encompasses a multi-method audit that may include structured interviews with key stakeholders, anonymous staff surveys, analysis of existing absence and turnover data, and a review of relevant policy documents. It is at this juncture that the Social GGRRAAACCEEESSS model is frequently invoked to ensure that the assessment captures the full socioecological breadth of the workplace, spanning spiritual, community, physical, organisational, economic, political, and environmental dimensions. By mapping findings onto this model, the practitioner can identify not only individual-level risk factors but also systemic patterns such as inadequate line-management training, misaligned performance metrics, or a paucity of psychologically safe communication channels. The involvement of occupational health psychologists, HR

business partners, and employee representatives at this stage reinforces the legitimacy of the data collected and begins to embed a culture of collaborative inquiry that will persist throughout the engagement.

The methodological rigour of the needs-assessment phase is further strengthened by the incorporation of validated screening tools that provide quantitative benchmarks against which later progress can be measured. The PHQ-9 and GAD-7, for instance, are routinely administered as part of a baseline assessment to establish a population-level snapshot of depressive and anxiety symptomatology within the workforce. Their administration is conducted in accordance with GDPR protocols, ensuring informed consent, data minimisation, and secure storage. These instruments do not replace comprehensive clinical assessment but serve as standardised epidemiological indicators that can be aggregated, tracked over time, and reported to organisational leadership in a format that is both clinically credible and operationally intelligible. The inclusion of such tools from the outset signals to the client that the consultancy engagement is grounded in an evidence base that values quantifiable outcome data alongside qualitative insight.

Once the needs-assessment data have been collated and analysed, the next critical task is the tailoring of content to the specific organisation's findings. This is the point at which the generic, off-the-shelf half-day course is decisively set aside in favour of a bespoke curriculum that directly addresses the gaps, risks, and opportunities revealed by the assessment. Content design is informed by the socioecological insights gathered, by the PHQ-9 and GAD-7 baseline scores, and by any thematic patterns that emerge from interview and focus-group data. For example, if the assessment uncovers that line managers feel ill-equipped to hold supportive conversations about mental health, the resulting training module will eschew generic wellbeing tips in favour of skill-based scenarios, role-play exercises, and a structured framework for conducting compassionate yet professionally bounded dialogues. If organisational data indicate high correlation between workload metrics and elevated PHQ-9 scores, the consultancy may design a multi-component intervention that includes both individual-level coping skills training and structural changes to workload distribution or deadline realism. This tailoring process ensures that every learning objective, activity, and resource is directly traceable to an identified need, thereby maximising the probability of engagement, relevance, and behavioural change. Moreover, by

grounding the content in the organisation's own data, the practitioner cultivates a sense of ownership and investment among stakeholders, who can see a clear line of sight from their lived experience to the proposed interventions.

The construction of before-and-after evaluation into the engagement from the start is what differentiates a genuine consultancy from a transactional training provider. Evaluation design is not an afterthought appended once the training has been delivered; rather, it is integral to the engagement contract, specified in the initial proposal and built into the project timeline alongside content development and delivery. A robust evaluation framework operates on multiple levels. At the reaction level, participants complete immediate feedback forms that assess perceived relevance, facilitator skill, and intent to apply learning. At the learning level, post-intervention PHQ-9 and GAD-7 administrations provide a within-group comparison of symptomatology change, while control group comparisons, where feasible, strengthen causal inference. At the behaviour and practice level, follow-up surveys or interviews at three-, six-, and twelve-month intervals assess whether newly acquired skills have been integrated into daily work routines, whether line-management practices have shifted, and whether reported sources of stress have diminished. At the organisational level, key performance indicators such as sickness absence rates, presenteeism estimates, staff turnover, and employee engagement survey scores are tracked against baseline figures. This multi-tiered evaluation architecture ensures that the consultancy can demonstrate not only that participants enjoyed the experience but that the organisation has, in measurable ways, moved towards its wellbeing objectives. The use of statistical analysis appropriate to the data type—such as paired t-tests for continuous PHQ-9/GAD-7 change, or chi-square tests for categorical absence outcomes—underscores the practice's commitment to methodological rigour and transparent reporting.

How this structure fits the practice's wider consultancy direction is a question of strategic alignment and brand positioning. Talking Therapies UK has, over recent years, articulated a clear intent to evolve from a provider of individual-focused therapeutic interventions towards a practice that offers high-impact, organisation-level consultancy. This shift is underpinned by a recognition that population-level wellbeing outcomes are often more effectively achieved by modifying the contexts in which individuals work,

rather than by attempting to remediate distress in isolation. The consultancy engagement model described here—with its mandatory needs-assessment, data-driven content tailoring, and embedded before-and-after evaluation—serves as the operationalisation of that strategic vision. It allows the practice to differentiate its offer in a crowded marketplace, where many competitors still promote one-size-fits-all half-day sessions that lack rigorous outcome measurement. By positioning the consultancy as a evidence-based, socioecologically informed, and evaluation-rich service, the practice attracts clients who value clinical accountability, who are answerable to boards or commissioners for wellbeing spend, and who seek sustainable change rather than short-term morale boosts. Furthermore, the model creates a virtuous feedback loop: data collected from one engagement inform the refinement of future offerings, strengthen the practice's research portfolio, and contribute to the development of thought-leadership content such as white papers, conference presentations, and contributions to guidelines issued by bodies such as the Health and Safety Executive or the National Institute for Health and Care Excellence. In this way, each consultancy engagement becomes both a service delivery event and a knowledge-generating activity, reinforcing the practice's reputation as a trusted partner in organisational wellbeing.

Ethical governance and data stewardship underpin every stage of the consultancy engagement, from the initial needs-assessment through to the final evaluation report. All data collection adheres to the UK General Data Protection Regulation, the Equality Act 2010, and the British Psychological Society's Code of Ethics and Conduct. Informed consent is obtained not only for the administration of screening instruments such as the PHQ-9 and GAD-7 but also for the use of aggregated organisational data in evaluation reports. Confidentiality protocols are clearly communicated, and data are stored on secure, encrypted systems accessible only to authorised members of the consultancy team. Where focus groups or interviews are conducted, participants are advised of the limits of confidentiality, particularly regarding the disclosure of self-harm or safeguarding concerns, in accordance with professional duty of care. The practice also maintains a transparent fees structure that reflects the additional value delivered by the needs-assessment, tailoring, and evaluation components, ensuring that clients understand what they are paying for and what outcomes they can reasonably expect. By embedding these ethical safeguards into the

consultancy model, the practice not only protects participants and the organisation but also enhances its own credibility and long-term sustainability.

In sum, the consultancy engagement as described in this lesson is far more than a rebranding of existing training offerings. It is a systematically structured, evidence-based process that begins with a rigorous needs-assessment informed by the Social GGRRAAACCEEESSS socioecological framework, proceeds to the tailoring of content that is directly responsive to organisational findings, and is anchored by a multi-tiered before-and-after evaluation that utilises validated tools such as the PHQ-9 and GAD-7 alongside organisational KPIs. This architecture ensures that the deliverables are clinically sound, organisationally relevant, and demonstrably effective. Moreover, the model fits squarely within the practice's wider consultancy direction, positioning Talking Therapies UK as a leader in the transition from generic workplace training to rigorous, impact-oriented organisational psychology. By committing to this depth of process and measurement, the practice not only fulfils the expectations of discerning corporate clients but also advances the broader field of workplace wellbeing through the generation of robust, reproducible data and the cultivation of a culture that values inquiry, accountability, and sustained psychological health.

Points worth keeping

- A needs-assessment stage before any training is designed
- Tailoring content to the specific organisation's findings
- Building before-and-after evaluation into the engagement from the start
- How this fits the practice's wider consultancy direction

PRACTICE TASK

Sketch a three-stage consultancy structure (assess, deliver, evaluate) for a workplace wellbeing engagement with a hypothetical client.

The end of the sample

This is a free sample of “Workplace Wellbeing in Practice”, and it ends here.

Everything you have read here is from the opening of the book, set exactly as it is printed in it. The rest follows in the same way, chapter by chapter, with its worksheets, its examples and its reference list.

The full book is on sale in the Talking Therapies UK shop. A copy is yours to keep, as a PDF and an ebook, licensed to you by name: a short line saying so is printed at the foot of each page of the PDF and on the title page of the ebook.